Clinical Data Content

The following Clinical Document content types will be used as foundation standards for exchanging information in North Carolina. A Technical Standards workgroup will be created who will review and assess the standards below and then make a formal to the Governance Body.

1. Summary Documents. The recommended standard for Summary Documents is the Continuity of Care Document (CCD), defined by HL7, and profiled by HITSP and the NHIN Cooperative. The committee recommends that CCD documents be created to encapsulate information from a single "patient encounter. The Medication History and Allergies document can also be encoded using the HL7 CCD.
2. Laboratory Results should be encoded as described in the IHE XD-Lab Document standard. Although Lab Results can be included in the CCD, the XD-Lab document has specific profile elements that describe how to encode unique elements related to the laboratory domain, such as the origin of specimens and the relationship between the specimen and the results.
3. PHR documents should be encoded using the HL7 CCD and the other formats listed here when the corresponding data type is being presented. This capability should be developed to support the ARRA requirement that health information about a person in electronic form be transmitted to that person in electronic form upon request.
4. Scanned Documents should be encoded as described in the IHE XDS-Scanned Document profile. This profile describes encoding a PDF document or plain text document as binary-encoded data inside the "non-structured" section of a CDA document. This standard calls for the use of the same structured metadata that applies to other document types to apply to scanned documents, allowing for robust searching and management of this inherently unstructured data.
5. Radiology reports and images will follow the content standards prescribed by the standards of the Digital Imaging and Communications in Medicine (DICOM), including the DICOM Structured Reports standard for reports. The format for images may follow the DICOM standards, or may simply use images viewed in a web browser, depending on the protocols used for exchanging these images.

Coded Healthcare Vocabularies

Providing healthcare data in a common structured format is the first step in enabling an EHR system to process and understand information created in a different EHR system. To enable complete "semantic" interoperability, a common vocabulary must used between the two systems. Standard healthcare vocabularies, often referred to as "coded" vocabularies, because of their use of alpha-numeric codes rather than English words or mnemonic phrases, are used to represent such concepts as symptoms, diagnoses, laboratory tests and results, admission types and medications.

A set of standard vocabularies have been published by the same standards agencies that defined the document formats. Adoption of these vocabulary standards is likely not achievable in the short term. Nonetheless, the NC HIE should set a target for the use of standard healthcare vocabularies wherever